Fermilab

[ ] Medical Office: Please confirm supervisor receipt.

ATTACHMENT 2

INJURY/ILLNESS EVALUATION FORM-5

To:

From: Medical Office:
After examination and evaluation of _____, I have determined that he/she is

( ) Returned to work with no limitations.
( ) Returned to work with the following limitations until _____:
( ) Unable to perform any work (sent home.)

"The individual is returned to work and will be re-evaluated on _____."

The above issues are/were due to Occupational Injury/Illness ( ) Yes ( ) No

Medical signature _____ Date _____

( ) Complete sections below, and return as directed. ( ) Information above is FYI for supervisor's files.

I have reviewed and understand the doctor's recommendations as listed above.

( ) The above restrictions do not limit the employee's ability to perform all required duties.

( ) The employee's job will be modified to accommodate the limitation noted above;

( ) The employee's job cannot be modified, but he/she will be given a different job assignment subject to the above limitations until such time as the limitations are removed; or

( ) The employee cannot perform any of his/her job duties with the above limitations and a change in job assignments is not available. (Please contact the Medical Office to discuss options.)

Supervisor signature/ID # _____Date _____

I have reviewed and understand the information noted above. I have discussed this information with the Laboratory's physician and my supervisor. I agree to make myself available for a re-evaluation on the date noted above. I will also notify the Medical Office if my condition improves before my next scheduled appointment and understand that if I do not comply with my restrictions, disciplinary action may result.

Employee signature _____Date _____

I have reviewed the above information.

Senior Safety Officer signature/ID # _____Date _____

(or designee)

This original form with ALL signatures must be returned to the Medical Office, MS 204, within 3 working days.

If there are any questions, please contact the Medical Office at extension 3232.

FORM 5*REV *OCT. 2000 * ES&H/MED
Distribution: Employee, ES&H (occupational only), and file.

ATTACHMENT 3

Injury Incident Involvement Form

Name: _____ I.D.#: _____ Date: _____

ON _____ [ ] I WITNESSED **or** [ ] WAS INVOLVED IN **an** [ ] INCIDENT or [ ] NEAR MISS
(date) (check the appropriate boxes above)

EMPLOYEE'S STATEMENT OF THE INCIDENT/NEAR MISS EVENTS

_____
(signature)

Date: _____ Telephone: 840- _____